		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. **IDPH Facility ID Number:** 0041749

Facility Name: Renaissance at Midway

Address: 4437 South Cicero (Number) Chicago (City) 60632 (Zip Code)

County: Cook

Telephone Number: 773-884-0484 **Fax #** 773-884-0485

IDPA ID Number: 36-3969662001

Date of Initial License for Current Owners: 06/05/00

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. **CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/05/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed) SEE ACCOUNTANT'S REPORT ATTACHED	(Date)
	(Print Name and Title)	
	(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C. 111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015	
	(Telephone) (847) 236-1111	Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds NA

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	249	Skilled (SNF)	249	52,290	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	249	TOTALS	249	52,290	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,534	752	2,445	8,731	8
9	SNF/PED					9
10	ICF	3,510	201		3,711	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,044	953	2,445	12,442	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 23.79%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/05/00

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date New Construction NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 50 and days of care provided 2,166

Medicare Intermediary AdminaStar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Rena # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	127,091	39,453	4,537	171,081		171,081		171,081			1
2	Food Purchase		93,736		93,736	(20,580)	73,156	(72)	73,084			2
3	Housekeeping		7,997	155,812	163,809		163,809		163,809			3
4	Laundry		39,553		39,553		39,553		39,553			4
5	Heat and Other Utilities			93,366	93,366		93,366	534	93,900			5
6	Maintenance	77,026	26,396	124,664	228,086		228,086	877	228,963			6
7	Other (specify):*							(13)	(13)			7
8	**TOTAL General Services**	204,117	207,135	378,379	789,631	(20,580)	769,051	1,326	770,377			8
	B. Health Care and Programs											
9	Medical Director			11,391	11,391		11,391		11,391			9
10	Nursing and Medical Records	966,549	87,320	23,679	1,077,548		1,077,548	652	1,078,200			10
10a	Therapy		1,090	19,152	20,242		20,242		20,242			10a
11	Activities	55,955	7,817	816	64,588		64,588		64,588			11
12	Social Services	69,638		5,429	75,067		75,067		75,067			12
13	Nurse Aide Training			7,934	7,934		7,934		7,934			13
14	Program Transportation			256	256		256	1,186	1,442			14
15	Other (specify):*							121	121			15
16	**TOTAL Health Care and Programs**	1,092,142	96,227	68,657	1,257,026		1,257,026	1,959	1,258,985			16
	C. General Administration											
17	Administrative	102,859		214,916	317,775		317,775	12,835	330,610			17
18	Directors Fees											18
19	Professional Services			55,192	55,192		55,192	1,184	56,376			19
20	Dues, Fees, Subscriptions & Promotions			313,914	313,914		313,914	(269,533)	44,381			20
21	Clerical & General Office Expenses	167,065		113,526	280,591		280,591	76,519	357,110			21
22	Employee Benefits & Payroll Taxes			263,063	263,063	20,580	283,643	(815)	282,828			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,478	8,478		8,478	649	9,127			24
25	Other Admin. Staff Transportation							326	326			25
26	Insurance-Prop.Liab.Malpractice			105,374	105,374		105,374	161	105,535			26
27	Other (specify):*							16,948	16,948			27
28	**TOTAL General Administration**	269,924		1,074,463	1,344,387	20,580	1,364,967	(161,726)	1,203,241			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,566,183	303,362	1,521,499	3,391,044		3,391,044	(158,441)	3,232,603			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway
0041749
COST REPORT RECLASSIFICATIONS
06/05/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	20,580	
2	FOOD		20,580

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number: The Claridge at Cicero, Inc. D/B/A The Renaissance at Midw #0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			48,436	48,436		48,436	175,749	224,185			30
31	Amortization of Pre-Op. & Org.			437,041	437,041		437,041	(386,889)	50,152			31
32	Interest			148,136	148,136		148,136	389,874	538,010			32
33	Real Estate Taxes			180,000	180,000		180,000		180,000			33
34	Rent-Facility & Grounds			6,000	6,000		6,000	6,316	12,316			34
35	Rent-Equipment & Vehicles			10,704	10,704		10,704	4,116	14,820			35
36	Other (specify):*											36
37	**TOTAL Ownership**			830,317	830,317		830,317	189,166	1,019,483			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	5,676	80,545	80,671	166,892		166,892	21	166,913			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,435	78,435		78,435		78,435			42
43	Other (specify):*	54,848			54,848		54,848	(54,848)				43
44	**TOTAL Special Cost Centers**	60,524	80,545	159,106	300,175		300,175	(54,827)	245,348			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,626,707	383,907	2,510,922	4,521,536		4,521,536	(24,101)	4,497,435			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at M # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(53,669)	30		9
10	Interest and Other Investment Income	(355)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(72)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(13,750)	17		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,320)	21		18
19	Entertainment	(14,033)	21		19
20	Contributions	(3,897)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(796)	21		24
25	Fund Raising, Advertising and Promotional	(262,649)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(458,895)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (809,436)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	785,335	VARIOUS	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 785,335		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (24,101)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway

ID# 0041749

Report Period Beginning: 06/05/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Misc. Income	(2,000)	21	2
3	Marketing Salaries	(54,848)	43	3
4	Legal Fees	(132)	19	4
5	Contributions - Political	(4,873)	20	5
6	Unamortized Pre-Opening Costs	(386,889)	31	6
7	Bldg Partnership - Legal Fees	(808)	19	7
8	Bldg Partnership - Accounting Fees	(8,515)	19	8
9	Bldg Partnership - Fees	(15)	19	9
10	Non-Allowable Employee Benefits	(815)	22	10
11				11
12				12
13				13
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86				86
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89				89
90	**Total**	(458,895)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midv # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(72)	0	0	0	0	0	0	0	0	0	0	(72)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	534	0	0	0	0	0	0	0	0	534	5
6	Maintenance	0	0	877	0	0	0	0	0	0	0	0	877	6
7	Other (specify):*	0	0	(13)	0	0	0	0	0	0	0	0	(13)	7
8	**TOTAL General Services**	(72)	0	1,398	0	0	0	0	0	0	0	0	1,326	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	652	0	0	0	0	0	0	0	0	652	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	1,186	0	0	0	0	0	0	0	0	1,186	14
15	Other (specify):*	0	0	121	0	0	0	0	0	0	0	0	121	15
16	**TOTAL Health Care and Programs**	0	0	1,959	0	0	0	0	0	0	0	0	1,959	16
	C. General Administration													
17	Administrative	(13,750)	0	(41,000)	119,139	(39,721)	(11,833)	0	0	0	0	0	12,835	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,470)	9,338	1,316	0	0	0	0	0	0	0	0	1,184	19
20	Fees, Subscriptions & Promotions	(271,419)	0	1,886	0	0	0	0	0	0	0	0	(269,533)	20
21	Clerical & General Office Expenses	(18,149)	0	89,986	0	4,682	0	0	0	0	0	0	76,519	21
22	Employee Benefits & Payroll Taxes	(815)	0	0	0	0	0	0	0	0	0	0	(815)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	649	0	0	0	0	0	0	0	0	649	24
25	Other Admin. Staff Transportation	0	0	326	0	0	0	0	0	0	0	0	326	25
26	Insurance-Prop.Liab.Malpractice	0	0	161	0	0	0	0	0	0	0	0	161	26
27	Other (specify):*	0	0	13,159	3,080	709	0	0	0	0	0	0	16,948	27
28	**TOTAL General Administration**	(313,603)	9,338	66,483	122,219	(34,330)	(11,833)	0	0	0	0	0	(161,726)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(313,675)	9,338	69,840	122,219	(34,330)	(11,833)	0	0	0	0	0	(158,441)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midv # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(53,669)	226,083	3,335	0	0	0	0	0	0	0	0	175,749	30
31	Amortization of Pre-Op. & Org.	(386,889)	0	0	0	0	0	0	0	0	0	0	(386,889)	31
32	Interest	(355)	391,792	(1,563)	0	0	0	0	0	0	0	0	389,874	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	6,316	0	0	0	0	0	0	0	0	6,316	34
35	Rent-Equipment & Vehicles	0	0	4,116	0	0	0	0	0	0	0	0	4,116	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(440,913)	617,875	12,204	0	0	0	0	0	0	0	0	189,166	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	21	0	0	0	0	0	0	0	0	21	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(54,848)	0	0	0	0	0	0	0	0	0	0	(54,848)	43
44	**TOTAL Special Cost Centers**	(54,848)	0	21	0	0	0	0	0	0	0	0	(54,827)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(809,436)	627,213	82,065	122,219	(34,330)	(11,833)	0	0	0	0	0	(24,101)	45

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	FEES	$	RENAISSANCE AT MIDWAY		$ 15	$ 15	1
2	V	19	LEGAL FEES		RENAISSANCE AT MIDWAY		808	808	2
3	V	19	ACCOUNTING FEES		RENAISSANCE AT MIDWAY		8,515	8,515	3
4	V	32	INTEREST EXPENSE		RENAISSANCE AT MIDWAY		391,792	391,792	4
5	V	30	DEPRECIATION EXPENSE		RENAISSANCE AT MIDWAY		226,083	226,083	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 627,213	$ * 627,213	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	NUCARE SERVICES CORP.	100.00%	$ 534	$ 534	15
16	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.		877	877	16
17	V	7	EMPLOYEE BEN. GEN. SERV.		NUCARE SERVICES CORP.		(13)	(13)	17
18	V	10	NURSING ADMIN. COMP.		NUCARE SERVICES CORP.		652	652	18
19	V	14	PROGRAM TRANSPORTATION		NUCARE SERVICES CORP.		1,186	1,186	19
20	V	15	HEALTHCARE BENEFITS		NUCARE SERVICES CORP.		121	121	20
21	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.		1,316	1,316	21
22	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.		1,886	1,886	22
23	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.		89,986	89,986	23
24	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.		649	649	24
25	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.		326	326	25
26	V	26	INSURANCE		NUCARE SERVICES CORP.		161	161	26
27	V	27	EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.		13,159	13,159	27
28	V	30	DEPRECIATION		NUCARE SERVICES CORP.		3,335	3,335	28
29	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.		(1,563)	(1,563)	29
30	V	34	BUILDING RENT		NUCARE SERVICES CORP.		6,316	6,316	30
31	V	35	EQUIPMENT RENTAL		NUCARE SERVICES CORP.		4,116	4,116	31
32	V	39	ANCILLARY		NUCARE SERVICES CORP.		21	21	32
33	V	17	MANAGEMENT FEES	41,000				(41,000)	33
34	V	0							34
35	V	0							35
36	V								36
37	V								37
38	V								38
39	Total			$ 41,000			$ 123,065	$ * 82,065	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - R. HARTMAN	$	NUCARE SERVICES CORP.	100.00%	$ 97,559	$ 97,559	15
16	V	17	ADMIN. - B. CARR		NUCARE SERVICES CORP.		20,850	20,850	16
17	V	17	ADMIN. - D. HARTMAN		NUCARE SERVICES CORP.		730	730	17
18	V	17	ADMIN. - E. DICKMAN		NUCARE SERVICES CORP.		0		18
19	V	27	EMP. BEN. - R. HARTMAN		NUCARE SERVICES CORP.		2,068	2,068	19
20	V	27	EMP. BEN. - B. CARR		NUCARE SERVICES CORP.		950	950	20
21	V	27	EMP. BEN. - D. HARTMAN		NUCARE SERVICES CORP.		62	62	21
22	V	27	EMP. BEN. - E. DICKMAN		NUCARE SERVICES CORP.		0		22
23	V	0					0		23
24	V	0					0		24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0							28
29	V	0							29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0							35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 122,219	$ * 122,219	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	J. RAJCHENBACH-COMP.	$	JLR MANAGEMENT CORP.	100.00%	$ 16,112	$ 16,112	15
16	V	21	OFFICE				515	515	16
17	V	27	PAYROLL TAXES				709	709	17
18	V	0					0		18
19	V	0					0		19
20	V	0					0		20
21	V	17	MARVIN NEEDLE-CONS. FEES				0		21
22	V	0					0		22
23	V	0					0		23
24	V	17	MARK BERGER-CONS. FEES				12,500	12,500	24
25	V	21	SECRETARIAL				4,167	4,167	25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	17	MANAGEMENT FEES	68,333			0	(68,333)	29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$ 68,333			$ 34,003	$ * (34,330)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT SERVICES	$ 11,833		100.00%	$	$ (11,833)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 11,833			$ 0	$ * (11,833)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	WORKER'S COMPENSATION INS.	$ 36,677	DIAMOND INSURANCE	100.00%	$ 36,677	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 36,677			$ 36,677	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Ren # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT HARTMAN	OWNER	Administrative	50%	SEE ATTACHED	4.94	7.6%	NuCare Mgmt	$ 97,559	17-7	1
2	ROBERT HARTMAN	OWNER	Administrative	50%	SEE ATTACHED	4.94	7.6%	Facility	70,000	17-3	2
3	BARRY CARR		Administrative		SEE ATTACHED	5.4	9.8%	NuCare Mgmt	20,850	17-7	3
4	BARRY CARR		Administrative		SEE ATTACHED	5.4	9.8%	Facility	11,216	17-3	4
5	MARK BERGER	Administrator	Administrative		SEE ATTACHED	33.33	83.32%	JLR Mgmt	12,500	17-7	5
6	MARK BERGER	Administrator	Administrative		SEE ATTACHED	33.33	83.32%	Facility	51,448	17-1	6
7	JACK RAJCHENBACH		Administrative		SEE ATTACHED	6	9.2%	JLR Mgmt	16,112	17-7	7
8	DAVID HARTMAN		Administrative		SEE ATTACHED	0.7	1.5%	NuCare Mgmt	730	17-7	8
9	BERNARD HOLLANDER		Administrative		SEE ATTACHED						9
10											10
11											11
12											12
13								TOTAL	$ 280,415		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at M # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at M # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 6677 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS	634,333	8	$ 6,475	$	52,290	$ 534	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	634,333	8	10,636	(714)	52,290	877	2
3	7	EMPLOYEE BEN. GEN. SERV.	AVAIL. CENSUS DAYS	634,333	8	(156)		52,290	(13)	3
4	10	NURSING ADMIN. COMP.	AVAIL. CENSUS DAYS	634,333	8	7,912	6,671	52,290	652	4
5	14	PROGRAM TRANSPORTATION	AVAIL. CENSUS DAYS	634,333	8	14,386		52,290	1,186	5
6	15	HEALTHCARE BENEFITS	AVAIL. CENSUS DAYS	634,333	8	1,462		52,290	121	6
7	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	634,333	8	15,970		52,290	1,316	7
8	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	634,333	8	22,883		52,290	1,886	8
9	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	634,333	8	1,091,620	894,249	52,290	89,986	9
10	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	634,333	8	7,875		52,290	649	10
11	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	634,333	8	3,960		52,290	326	11
12	26	INSURANCE	AVAIL. CENSUS DAYS	634,333	8	1,958		52,290	161	12
13	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	634,333	8	159,629		52,290	13,159	13
14	30	DEPRECIATION	AVAIL. CENSUS DAYS	634,333	8	40,461		52,290	3,335	14
15	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	634,333	8	(18,956)		52,290	(1,563)	15
16	34	BUILDING RENT	AVAIL. CENSUS DAYS	634,333	8	76,619		52,290	6,316	16
17	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	634,333	8	49,932		52,290	4,116	17
18	39	ANCILLARY	AVAIL. CENSUS DAYS	634,333	8	253	208	52,290	21	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,492,919	$ 900,414		$ 123,065	25

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at M # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: JLR MANAGEMENT CORP.
Street Address: 6633 NORTH LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60645
Phone Number: (847) 679-9141
Fax Number: (847) 679-1820

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	61	9	$ 163,800	$ 163,800	6	$ 16,112	1
2	21	OFFICE	AVG. HOURS WORKED	61	9	5,235		6	515	2
3	27	PAYROLL TAXES	AVG. HOURS WORKED	61	9	7,210		6	709	3
4										4
5										5
6										6
7	17	MARVIN NEEDLE-CONS. FEES	AVG. HOURS WORKED	40	1	46,296				7
8										8
9										9
10	17	MARK BERGER-CONS. FEES	AVG. HOURS WORKED	40	2	15,000		33.33	12,500	10
11	21	SECRETARIAL	AVG. HOURS WORKED	40	2	5,000		33.33	4,167	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 242,541	$ 163,800		$ 34,003	25

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at M # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 6677 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	37	8	720,633	720,000	5	97,559	1
2	17	ADMIN. - B. CARR	AVG. HOURS WORKED	40	8	154,447	151,667	5	20,850	2
3	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED	12	8	12,200	12,000	1	730	3
4	17	ADMIN. - E. DICKMAN	AVG. HOURS WORKED	35	1	3,500	3,500			4
5	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	37	8	15,274		5	2,068	5
6	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED	40	8	7,034		5	950	6
7	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED	12	8	1,028		1	62	7
8	27	EMP. BEN. - E. DICKMAN	AVG. HOURS WORKED	35	1	317				8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 914,433	$ 887,167		$ 122,219	25

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at M # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPATH HEALTH NETWORK
Street Address: 6633 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (888) 707-6700
Fax Number: (888) 679-2150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at M # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DIAMOND INSURANCE
Street Address: 40 SKOKIE BLVD. STE 105
City / State / Zip Code: NORTHBROOK, IL 60062
Phone Number: (847) 559-1002
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	WORKER'S COMP. INS.	DIRECT ALLOCATION			$	$		$ 36,677	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 36,677	25

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at M # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at M # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at M # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at M # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Rena # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	AMERICAN NAT'L BANK		X	Line of Credit						0.0950	79,802	6
7	STOCKHOLDERS	X						1,000,000		0.0950	59,819	7
8	CIB BANK		X	Line of Credit						0.0850	7,884	8
9	TOTAL Facility Related						$	$ 1,000,000			$ 147,505	9
	B. Non-Facility Related*											
10	Supplemental Schedule										390,505	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 390,505	14
15	TOTALS (line 9+line14)						$	$ 1,000,000			$ 538,010	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaiss: # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Other						$	$			$ 631	1
2	Interest Income										(355)	2
3												3
4	Claridge at Cicero - LT	X		MORTGAGE							391,792	4
5												5
6	NuCare Allocation	X									(1,563)	6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 390,505	21

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 **Report Period Beginning:** 06/05/00 **Ending:** 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	180,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	180,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 98,303 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 437,041
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 50,152
4. Dates Incurred: Various

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	48,972	1994	$ 850,000	1
2					2
3	TOTALS	48,972		$ 850,000	3

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	249		2000	2000	$ 9,107,497	$ 129,325	40	$ 151,792	$ 22,467	$ 151,792	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PRVDE A/C TO STF DNR			2000	1,716	17	20	36	19	36	9
10	INSTALL LANDSCAPING			2000	9,637	113	20	241	128	241	10
11	INSTL WNDW GRD SYSTM			2000	13,170	183	20	384	201	384	11
12	SIGNS			2000	415	6	20	11	6	12	12
13	WIRING FOR PHONES,CO			2000	28,197	392	20	823	431	823	13
14	WALLPAPER			2000	4,039	56	20	118	62	118	14
15	CARPET			2000	1,123	16	20	33	17	33	15
16	WINDOW TREATMENTS			2000	1,244	17	20	36	19	36	16
17	FRNSH & INSTL FLG PL			2000	1,471	21	20	43	22	43	17
18	BALANCE OWED ON CNPS			2000	7,804	92	20	195	103	195	18
19	WINDOW TREATMENT			2000	483	6	20	12	6	12	19
20	WINDOW TREATMENT			2000	3,992	47	20	100	53	100	20
21	INSTALL PHONE SYSTEM			2000	4,861	5	20	20	15	20	21
22	CORNICE BRDS & VLNCS			2000	3,794	44	20	95	51	95	22
23	PREP WALLS & HNG WLP			2000	5,980	70	20	150	80	150	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32	PAGE 12-1 REP				1,745	129		71	(58)	147	32
33											33
34	PAGE 12B TOTALS				5,226	138		171	33	171	34
35	PAGE 12A TOTALS				93,145	782		1,722	940	1,722	35
36	TOTAL (lines 4 thru 35)				$ 9,295,539	$ 131,459		$ 156,053	$ 24,595	$ 156,130	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PREP WALLS & HNG WLP			2000	3,990	38	20	83	45	83	9
10	CHR RLS, END CAP,WLG			2000	6,605	63	20	138	75	138	10
11	PHONE & CMPTR CBLG			2000	4,959	48	20	103	55	103	11
12	WALLPAPER			2000	208	2	20	4	2	4	12
13	CORNICE BRDS, DRAPER			2000	1,194	12	20	25	13	25	13
14	WINDOW TREATMENTS			2000	6,442	62	20	134	72	134	14
15	WINDOWS			2000	3,933	55	20	115	60	115	15
16	CCTV & CMPTR CABLEIN			2000	5,056	49	20	105	56	105	16
17	CUBICLE CRTNS, SHDS			2000	3,798	36	20	79	43	79	17
18	INHOUSE PAGING SYSTM			2000	5,554	41	20	93	52	93	18
19	FLUID PUMP SERVICE			2000	1,246	9	20	21	12	21	19
20	SCREENS			2000	630	3	20	8	5	8	20
21	REPLC FLR IN SRVC EL			2000	1,750	9	20	22	13	22	21
22	SQUARE DEAL GLASS			2000	626	3	20	8	5	8	22
23	WANDER GUARD SYSTEM			2000	1,088	4	20	9	5	9	23
24	INSTALL PHONE SYSTEM			2000	8,600	28	20	72	44	72	24
25	PHONE, CCTV & CMPTR			2000	16,579	53	20	138	85	138	25
26	REPAIRS TO BOILER			2000	927	1	20	4	3	4	26
27	FENCE			2000	2,215	31	20	65	34	65	27
28	CABLEING FOR CMPTR S			2000	604	1	20	3	2	3	28
29	REPAIR FIRE ALARM PN			2000	866	8	20	18	10	18	29
30	CORNER GUARDS			2000	1,438	20	20	42	22	42	30
31	CARPET & DRAPERIES			2000	3,622	50	20	106	56	106	31
32	WALLPAPER			2000	1,277	18	20	37	19	37	32
33	DRAPERIES & SHWR CBL			2000	1,758	24	20	51	27	51	33
34	CABINETS			2000	6,200	86	20	181	95	181	34
35	CABINETS			2000	1,980	28	20	58	30	58	35
36	TOTAL (lines 4 thru 35)				$ 93,145	$ 782		$ 1,722	$ 940	$ 1,722	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LOCKS			2000	611	9	20	18	9	18	9
10	AMERICAN HEALTHCARE			2000	488	7	20	14	7	14	10
11	GRAVEL FOR PRKG LOT			2000	3,500	49	20	102	53	102	11
12	BED, MOBILE MONITOR			2000	627	73	20	37	(36)	37	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 5,226	$ 138		$ 171	$ 33	$ 171	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOC. - NUCARE MANAGEMENT			1997	380	10	20	19	9	61	9
10	ALLOC. - NUCARE MANAGEMENT			1998	333	8	20	17	9	41	10
11	ALLOC. - NUCARE MANAGEMENT			1999	466	105	20	23	(82)	33	11
12	ALLOC. - NUCARE MANAGEMENT			2000	566	6	20	12	6	12	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,745	$ 129		$ 71	$ (58)	$ 147	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissan # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 16,057	$ 2,539	$ 1,386	$ (1,153)		$ 8,898	37
38	Current Year Purchases	1,225,574	143,857	66,746	(77,111)		66,746	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 1,241,631	$ 146,396	$ 68,132	$ (78,264)		$ 75,644	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 11,387,170	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 277,855	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 224,185	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (53,669)	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 231,774	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53	Processing, Inspection, Exam Fees	203,948	3,398	3,398	53
54					54
55					55
56					56
57	TOTALS	$ 203,948	$ 3,398	$ 3,398	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Mid # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 9,574 Description: Toshiba - Copy Machines 5,458 + Alloc.NuCare - 4,116
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Business	Honda-1998 Acura	$ 700.00	$ 5,246	17
18					18
19					19
20					20
21	TOTAL		$ 700.00	$ 5,246	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$ 7,934	$ 7,934
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$ 7,934	$ 7,934
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			80,671			80,671	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				56,261		56,261	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**						24,284		24,284	13
14	TOTAL			$		$ 80,671	$ 80,545		$ 161,216	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	
2	Complex Medical Equip	10,400
3	Oxygen	
4	Equipment Rental	4,912
5	Laboratory	4,468
6	Enteral Feeding	4,504
7		
8		
9		
10		
		24,284

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Mid # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits	4,998	4,998	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,404,796	1,404,796	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	59,907	59,907	6
7	Other Prepaid Expenses	40,857	40,857	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,510,558	$ 1,510,558	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		850,000	13
14	Buildings, at Historical Cost		8,058,906	14
15	Leasehold Improvements, at Historical Cos	186,297	186,297	15
16	Equipment, at Historical Cost	392,809	1,222,164	16
17	Accumulated Depreciation (book methods)	(48,436)	(274,519)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		1,311,278	22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 530,670	$ 11,354,126	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,041,228	$ 12,864,684	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,069,503	$ 1,357,151	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,445,271	2,445,271	29
30	Accrued Salaries Payable	236,315	236,315	30
31	Accrued Taxes Payable (excluding real estate taxes)	57,742	57,742	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	89,092	89,092	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,897,923	$ 4,185,571	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,000,000	4,663,021	39
40	Mortgage Payable		7,500,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,000,000	$ 12,163,021	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,897,923	$ 16,348,592	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,856,695)	$ (3,483,908)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,041,228	$ 12,864,684	48

*(See instructions.)

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at M# 0041749 **Report Period Beginning:** 06/05/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow		

OTHER CURRENT LIABILITIES:	Amount	Amount
Accrued Expenses		
Accrued R. E. Tax - Non Care Property		
Accrued Management Fees	88,000	
Wage Assignment	132	
Exchange	220	
Due from Employees	740	
	89,092	

OTHER NON CURRENT ASSETS:		
Construction In Progress		
Utility Deposit		
Loan Costs		

OTHER NON CURRENT LIABILITIES:		

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$		1
2	Restatements (describe):			2
3	**Schedule attached**			3
4				4
5				5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$		6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		(2,856,695)	7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants			11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners	(	)	13
14	Donated Property, Plant, and Equipment			14
15	Other (describe)			15
16	Other (describe)			16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$	(2,856,695)	17
	B. Transfers (Itemize):			
18				18
19				19
20				20
21				21
22				22
23	**TOTAL Transfers (sum of lines 18-22)**	$		23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$	(2,856,695)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissanc # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,660,923	1
2	Discounts and Allowances for all Levels	(189,732)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,471,191	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	106,911	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 106,911	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,280	19
20	Radiology and X-Ray		20
21	Other Medical Services	77,104	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 84,384	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	355	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 355	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	2,000	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,000	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,664,841	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	789,631	31
32	Health Care	1,257,026	32
33	General Administration	1,344,387	33
	B. Capital Expense		
34	Ownership	830,317	34
	C. Ancillary Expense		
35	Special Cost Centers	221,740	35
36	Provider Participation Fee	78,435	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,521,536	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,856,695)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,856,695)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A T # 0041749 **Report Period Beginning:** 06/05/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	
2	Misc. Income (Billboard income)	2,000
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	2,000

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midw # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	878	922	$ 50,201	$ 54.45	1
2	Assistant Director of Nursing	1,580	1,609	46,040	28.61	2
3	Registered Nurses	10,419	10,515	224,811	21.38	3
4	Licensed Practical Nurses	14,203	15,801	281,091	17.79	4
5	Nurse Aides & Orderlies	38,981	39,222	327,812	8.36	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	152	165	5,676	34.40	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,832	1,942	31,630	16.29	9
10	Activity Assistants	2,950	3,094	24,325	7.86	10
11	Social Service Workers	6,358	6,587	69,638	10.57	11
12	Dietician					12
13	Food Service Supervisor	2,250	2,310	44,264	19.16	13
14	Head Cook	2,751	2,804	25,542	9.11	14
15	Cook Helpers/Assistants	7,806	7,987	57,285	7.17	15
16	Dishwashers					16
17	Maintenance Workers	4,933	5,031	77,026	15.31	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	922	1,095	51,448	46.98	20
21	Assistant Administrator	1,056	1,088	27,897	25.64	21
22	Other Administrative	958	1,065	23,514	22.08	22
23	Office Manager					23
24	Clerical	13,522	13,998	167,065	11.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,956	2,224	36,594	16.45	31
32	Other Health Care(specify)					32
33	Other(specify)	2,050	2,166	54,848	25.32	33
34	TOTAL (lines 1 - 33)	115,557	119,625	$ 1,626,707 *	$ 13.60	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	103	$ 4,537	1-3	35
36	Medical Director	228	11,391	9-3	36
37	Medical Records Consultant	20	900	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	45	2,244	10-3	39
40	Physical Therapy Consultant	64	3,098	10a-3	40
41	Occupational Therapy Consultant	318	16,055	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	816	11-3	44
45	Social Service Consultant	119	5,429	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	913	$ 44,470		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	175	$ 6,770	10-3	50
51	Licensed Practical Nurses	182	5,526	10-3	51
52	Nurse Aides	462	8,238	10-3	52
53	TOTAL (lines 50 - 52)	819	$ 20,534		53

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
MARKETING SALARIES	2,050	2,166	$ 54,848	$ 25.32
	2,050	2,166	$ 54,848	$ 25.32

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissanc # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Berger	Administrator	0	$ 51,448
Brian Celeria	Asst. Admin.	0	27,897
Pat Finn	Administrative	0	23,514
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 102,859

B. Administrative - Other

Description	Amount
Management Fees - See Attached Schedule	$ 214,916
TOTAL (agree to Schedule V, line 17, col. 3)	$ 214,916
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
See schedule attached	Computer Services	22,447
Personnel Planners	U.C. Consultant	173
FR&R	Accounting Fees	11,590
See schedule attached	Legal Fees	20,982
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 55,192

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 42,307
Unemployment Compensation Insurance	37,632
FICA Taxes	123,443
Employee Health Insurance	22,990
Employee Meals	20,580
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	2,138
Employee Benefits	32,646
City Payroll Taxes	1,092
TOTAL (agree to Schedule V, line 22, col.8)	$ 282,828

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 250
Advertising: Employee Recruitment	22,186
Health Care Worker Background Check	2,681
(Indicate # of checks performed 289)	
Advertising & Promotion	262,649
Classified Advertising	9,888
Licenses, Permits & Fees	3,501
Association Dues	3,196
Dues & Subscriptions	793
NuCare Alloc	1,886
Less: Public Relations Expense	(262,649)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 44,381

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	8,478
NuCare Alloc	649
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,127

**See instructions.

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Mi # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number The Claridge at Cicero, Inc. D/B/A The Renaissance at Midway # 0041749 Report Period Beginning: 06/05/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS COUNCIL LTC-$1,900**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **N/A** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **8,025** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **N/A** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **78,435**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **20,580** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% In 1**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw